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IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

CALIFORNIA AMBULANCE ASS'N and
CALIFORNIA MEDICAL ASS'N ET AL.
Petitioners

v.

S. KIMBERLY BELSHE, Director of the California
Department of Health Services,
and
DONNA E. SHALALA, Secretary of the United States
Department of Health and Human Services,
Respondents

On Petition for Writ of Certiorari To The United States Court of Appeals For The Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether, prior to the enactment of the Balanced Budget Act of 1997, the Medicaid Act (42 U.S.C. sections 1396a(a)(10)(E), 1396a(n), and 1396d(p)) permitted states to limit or eliminate their Medicare "cost-sharing" payments for "Qualified Medicare Beneficiaries"?

2. What deference, if any, should the courts give to the views of a subsequent Congress that purports to clarify or interpret the intent of a statute enacted by an earlier Congress, and, if deference is to be given, what standards or principles, as well as judicial obligations, should guide the courts in determining the extent of such deference?

3. Whether Congress, consistent with Article III of the Constitution, may apply a new law to direct the outcome of litigation to which the United States is a party in order to benefit the federal government without changing the law retroactively as to non-litigants?

4. Whether a retroactive change in the law, resulting in a reduction of the statutory rate of payment to health care providers for services already provided to certain federal beneficiaries impairs vested property rights protected by the Takings Clause of the Fifth Amendment to, and by Article I, §10 of, the U.S. Constitution.

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The California Ambulance Association, the California Medical Association, and other physician associations (collectively "Associations" or "Petitioners")[1] respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit in this case in favor of respondents, Donna E. Shalala, as Secretary of the United States Department of Health and Human Services ("Secretary") and S. Kimberly Belshe, as Director of the California Department of Health Services ("State Director").

OPINIONS BELOW

The opinion of the Court of Appeals (App., 1-23) is reported at 132 F.3d 1259. The opinions of the district court (App. 26-31) are unreported.

JURISDICTION

The Court of Appeals filed its opinion and entered its judgment on December 2, 1997. App. 1. A petition for rehearing and suggestion for rehearing en banc was denied on March 3, 1998 (App. 24-25). The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

U.S. Constitution: Article I, §10; Art. III; 5th Amend.

42 U.S.C. §§1396a(a)(10)(E)(i),§1396a(a)(15) (repealed), §1396a(n), §1396d(p)(1), §1396d(p)(3).

Balanced Budget Act of 1997, Pub. L. 105-33, §4714.

California Welfare & Institutions Code §§14109, 14109.5

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[1] California Academy of Family Physicians; California Society of Anesthesiologists; California Urological Association; California Chapter of the American College of Emergency Physicians; California Chapter of the American College of Cardiology; California Society of International Medicine; California Society of Physical Medicine and Rehabilitation; California Radiology Society; Chapter of The American College of Radiology, Petitioners. There are no parent or subsidiary (other than wholly owned subsidiary) corporations of Petitioners.

STATEMENT OF THE CASE

I. Procedural History

In two separate actions (subsequently consolidated on appeal) in the United States District Court for the Central District of California, Petitioners challenged the California Medicaid ("Medi-Cal") program's refusal to pay its share of Medicare deductibles and co-insurance for medical services rendered by the Associations' members to patients known as Qualified Medicare Beneficiaries ("QMBs"). QMBs are patients who are "bought in" to the Medicare program by the state's payment of their Medicare premiums. At issue in these cases was whether certain 1986 and 1988 amendments to the Medicare and Medicaid Acts required the states to base their reimbursement obligation for such services to QMBs on the Medicare rate rather than the lower Medicaid rate. Jurisdiction for these actions was based on 28 U.S.C. §1331.

The district court granted summary judgments in favor of Petitioners, agreeing with and following the four circuits that had previously decided the same issue of statutory construction. App. 26-31. See *New York City Health and Hospital Corp. v. Perales*, 954 F.2d 854 (2nd Cir. 1992) *cert. den.* 113 S.Ct. 461 (1992) ("*Perales*"); *Pennsylvania Medical Society v. Snider*, 29 F.3d 866 (3rd Cir. 1994) ("*Snider*"); *Haynes Ambulance Service v. Alabama*, 36 F.3d 1074 (11th Cir. 1994) ("*Haynes*"); and *Rehabilitation Association of Virginia v. Kozlowski*, 42 F.3d 144 (4th Cir. 1994) *cert. den.* 116 S.Ct. 60 (1995) ("*Kozlowski*").

While appellants' appeals were pending before the Ninth Circuit, Congress passed the Balanced Budget Act ("BBA") of 1997, effective August 5, 1997. Pub. L. No. 105-33, 111 Stat. 251, *et seq.*. In response to these court decisions, Section 4714 of the BBA stated that its provisions were intended to "clarify" certain provisions of the QMB program (i.e., 42 U.S.C. §§1396a(n), 1396d(p)),[2] that were originally enacted in 1986, so

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[2] All subsequent statutory references will be to Title 42 of the United States Code unless otherwise noted.

as to permit states to eliminate or reduce payments for Medicare cost-sharing for QMBs by using lower Medicaid payment rates. The new provisions were made effective as of the date of enactment, August 5, 1997, *except* they were made *retroactive* as to payments by a state before the date of enactment if such payments were the subject of lawsuit based on the provisions of §§1396a(n) and 1396d(p) and pending as of or after August 5, 1997. 111 Stat.510.[3]

The Ninth Circuit recognized that if §4714 were to be characterized as a change in the law, "its retroactive application would pose a series of potential constitutional problems," since the medical services at issue had been provided before the 1997 amendments were passed. 132 F.3d at 1265. Nevertheless, the Ninth Circuit reversed the judgment below, holding that Supreme Court precedent required it to give "great weight" to congressional legislation that purported to express the "intent" of an earlier statute. Accordingly, while acknowledging that four circuit courts prior to the BBA "uniformly rejected [the] Secretary's reading" of the applicable statutes, 132 F.3d at 1266, it split with the other circuits and held that the Medicaid Act, as "clarified," by the Congress did permit the States to limit cost-sharing payments for medical services to QMBs at the Medicaid rate.

Appellants' Petition for Rehearing and Suggestion for Rehearing En Banc was denied on March 3, 1998.[4]

II. Summary of Issues Presented

At its core, this case involves the question of the proper construction of certain statutory provisions, originally enacted in 1986, defining the States' reimbursement obligation for Medicare

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[3] The Congressional Budget Office estimated that this provision which "overturns these decisions" would generate approximately $2.1 billion in net federal savings during 1998 through 2002. App. 47-48.

[4] The recent decision of the Seventh Circuit Court of Appeals in *Paramount Health System v. Wright*, 138 F.3d 706 (7th Cir. 1998), also deferred to the 1997 Congress' purported clarification.

services provided to QMBs under the Medicare and Medicaid Acts, an issue on which there is now a direct conflict among circuits which has enormous financial consequences for Petitioners' members. As a result of congressional action taken in 1997 while this case was pending on appeal, this case now presents a far broader constitutional issue arising from the Ninth Circuit's election to defer to Congress' purported "clarification" of the 1986 QMB legislation in the 1997 BBA, although (a) the Ninth Circuit's opinion offers no analysis of the meaning and intent of the 1986 legislation or of the reasonableness of the 1997 Congress' purported "clarification" of that legislation; and (b) to accord such deference required the Ninth Circuit to adopt a construction of the 1986 QMB legislation in direct conflict with the considered judgments of the four circuits that had previously considered the issue. As a result, this case now squarely presents the question as to the extent, and subject to what principles and standards, the courts should defer to congressional legislation purporting to clarify rather than amend earlier legislation enacted by a different Congress, especially where that purported clarification directly conflicts with intervening court decisions construing the earlier legislation and to apply that clarification retroactively would impair constitutionally-protected property rights.

A. Statutory Scheme

Because this case centers upon the proper judicial construction and interpretation of the statutes relating to the appropriate rate of reimbursement for providers of medical services to QMBs, a very brief summary of the QMB legislation and its statutory context is helpful.

Medicare. When Congress established the Medicare program in 1965 to ensure adequate medical care for the aged of this country, coverage was divided primarily into two parts, Part A covering all in-patient hospital expenses through an insurance plan, §§1395c-1395i-4, and Part B covering certain physician, ambulance, hospital, out-patient and other medical and health services not covered by Part A. §1395j-1395w-4(j). All Medicare-eligible patients receive Part A benefits. To be eligible for Part B benefits, however, Medicare-eligible patients must first enroll in the Part B insurance program by paying the Part B insurance premium. §1395o-1395s. After a Medicare-eligible

patient is enrolled in Part B, the federal government pays 80% of the Medicare allowable charge (§1395*l*), the patients themselves pay the remaining 20% of such charges, described as co-payments or co-insurance, as well as an annual deductible (§1395cc(a)(2)(A)). Together the Part B premiums, deductibles and 20% co-payments are referred to "Part B Cost-Sharing."

Medicaid. The Medicaid Act, which is designed to ensure medical services to the poor, establishes federal/state-funded program separate from Medicare, with the federal government overseeing the state's compliance with federal law (§1396c) and contributing approximately 50-80% of the funding with the states being responsible for the rest (§§1396b, 1396d(b)). States are not required to participate in the Medicaid program, but if they elect to do so, they must comply with the Medicaid Act and its implementing regulations. §1396c. Among other things, participating states must propose a plan that meets certain statutory requirements including the establishment of a schedule of Medicaid payment rates or reimbursement methods for the various kinds of medical care that a Medicaid patient may seek. §1396a(a)(30)(A).

Qualified Medicare Beneficiaries. For twenty years prior to 1986, states were required to make Medicare cost-sharing payments for dual-eligible individuals who were eligible for benefits under both Medicare and state Medicaid programs. 42 U.S.C. §1396a(15) (repealed). *See , infra*, at II.B.

In an effort to assure that the elderly poor received the full range of Medicare Part B services, Congress passed, as part of Omnibus Budget Reconciliation Act of 1986, the QMB amendments which are the focus of the present consolidated actions. Pub. L. No. 99-509, §9403, 100 Stat. 1874, 2053-55 (codified as amended) at §§1396a(a)(10)(E), 1396d(p), 1396a(n). These amendments gave states the option to use Medicaid funds to pay the Medicare Part B cost-sharing for a new category of Medicare-eligible individuals too poor to pay the Part B cost sharing on their own, but not poor enough to be Medicaid-eligible (§1396d(p)(1)). These individuals are commonly referred to as Qualified Medicare Beneficiaries or "QMBs." Section 1396a(a)(10)(E)(i) as originally enacted provided that a state Medicaid plan may provide "for making medical assistance available for Medicare cost-sharing (as defined in §1396d(p)(3) of

this title) for qualified Medicare beneficiaries described in §1396d(p)(1)." Section 1396d(p)(3) defines Medicare cost-sharing to include premiums, co-insurance and deductibles. States were required to cover these costs regardless of whether the same service could be covered under the state's Medicaid plan §1396d(p).

In addition, the 1986 amendments to the Medicaid Act provided that payment for QMBs would be subject to the provisions of newly-enacted §1396a(n), which clarified that "the total of Medicaid payments for Medicare cost-sharing charges together with Medicare payments may exceed the amounts otherwise payable under the State Medicaid plan for such services." H.R. Rep. No. 99-1012, 99th Cong., 2d Sess. 395-96 (1986), reprinted in 1986 U.S.C.C.A.N. 3868, 4040-4.

In 1988, Congress eliminated the states' option as to Part B Medicare services, amending §1396a(a)(10)(E) to *require* states to provide Medicare Part B benefits to pure QMBs. Pub. L. No. 100-360, §301(a)(1), 102 Stat. 683, 748. It also made all "dual eligibles," that is, patients eligible for benefits under both Medicare and Medicaid, in effect QMBs by repealing §1396d(p)(1)(B) (Pub. L. No. 100-647, §8434(a), 102 Stat. 3342, 3805), and §1396a(a)(15) (Pub. L. No. 100-485, §608(d)(14)(I), 102 Stat. 2343, 2416).

B. Federal Regulations and State Medicaid Manual

For almost two decades between 1971 and 1989, the Secretary's official policy -- contrary to the one she has assumed in this litigation -- was to require participating State Medicaid programs to pay, in addition to the Part B premium, the Part B 20% coinsurance and annual deductible amount for services provided to "dual eligible" beneficiaries under Part B. For example, in 1983, respondent Secretary issued a notice of proposed rule-making published in the Federal Register in which the agency's long-standing position was clearly set forth:

> Since 1971, HHS policy has been to require State agencies that have a "buy-in" agreement to pay, in addition to the Part B premium, the Part B coinsurance and deductible amount for services provided to beneficiaries under Part B, even if the services are not routinely provided under the Medicaid State Plan...In effect, if a State agency enters into a "buy-in"

> agreement, all the benefits under Part B have become part of the State plan for beneficiaries covered under the agreement.

48 Fed. Reg. 10378, 10379 (Mar. 11, 1983). See also 52 Fed. Reg. 47926, 47928 (Dec. 17, 1987).

In 1989, after the first actions were filed in the series of cases that resulted in the four Court of Appeal decisions pre-dating the 1997 Balanced Budget Act amendments, the DHHS Health Care Financing Administration ("HCFA") for the first time reversed its long-standing official position. Section 3490 of the revised guidelines for state Medicaid programs, set forth in the "State Medicaid Manual," purported to establish guidelines for the "Coverage of Qualified Medicare Beneficiaries For Medicare Cost Sharing Expenses." Under §3490.14, when a QMB incurs liability for services which are subject to the Medicare deductible or Medicare co-payments, the state's actual payment under the Medicaid reimbursement rate provided for in the State Plan is deemed payment in full for Medicare deductibles and co-insurance.[5]

C. California's Medi-Cal Program

California has elected to participate in the Medicaid program under the Medi-Cal Act. Welf. & Inst. Code, §§14000 et seq.; 22 Cal. Code Regs. §§50000 et seq. The state Medicaid plan provides for payment of the cost of any deductibles or cost sharing that QMBs may be entitled to under Medicare (Cal. Welf. & Inst. Code §14109) but limits the reimbursement rates for QMBs to the extent feasible to the Medi-Cal, rather than the Medicare, reimbursement rate. (Cal. Welf. & Inst. Code §14109.5.) With respect to payment for physician services under the Medi-Cal Program, the California Department of Health Services implemented this payment limitation for QMBs through Medi-Cal Services Bulletin No. 171 issued in 1989. Under said Bulletin, effective July 1, 1989, the combined Medicare/Medi-Cal

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[5] Two of the four circuit court opinions predating the BBA expressly declined to give deference to the Secretary's interpretation of the statutory provisions, in part, due to the inconsistency in the Secretary's position. *Snider*, 29 F.3d at 902; *Perales*, 954 F.2d at 862.

payment for all services of a claim may not exceed the amount allowed by Medi-Cal for all services of that claim.

HCFA approved the California Medicaid plan which purports to limit the reimbursement rate for QMBs to the Medi-Cal reimbursement rate. As a result, California's implementation of the QMB program caused Petitioners' members to receive no payments or dramatically lower payments for co-insurance and deductibles otherwise due them for services to QMBs.

III. Proceedings Below

The Associations challenged California's attempt to limit its reimbursement for Medicare services to QMBs to the Medi-Cal reimbursement rate. Since Medicare's payments of 80% of the Medi-Care-allowable charge virtually always exceeded the applicable Medi-Cal rate for the same service, Medi-Cal generally paid Petitioners' members $0 for the remaining 20% balance otherwise due under Medicare for their services.

Based on these facts, which were essentially undisputed, the district court granted Petitioners' summary judgment motion, finding that "Under the federal Medicare and Medicaid Acts, including but not limited to 42 U.S.C. §§1396a(a)(10)(E), 1395d(p)(1) and 1396d(p)(3), appellants' members, who provide medical services to qualified Medicare beneficiaries, are entitled to compensation for such services at 80% of the allowable medical rate plus full Medicare cost-sharing amounts." App. 26-30. The court further found that the amount of such cost-sharing is not limited by the Medi-Cal reimbursement rate for such services and to the extent California's statutes, regulations and bulletins provided to the contrary, they violated appellants' members' rights under the statutes cited above. App. 27, 30. Finally, the court noted that while it had considered independently all of the issues presented, it adopted the comprehensive analyses of the same statutes in *Perales*, *Snider*, *Haynes* and *Kozlowski*. The district court agreed with the four circuits rendering these decisions, "that the government's statutory construction would render the provisions of the Medicare and Medicaid Acts internally inconsistent and undermine the congressional purposes of the provisions in question." App. 27-28.

While the appeals of the Secretary and the State Director were pending, Congress enacted the Balanced Budget Act of

1997, §4714 of which addressed issues directly involved in this appeal by purporting to enact a "clarification" of §1396a(n) in response to the circuit court of appeals that had interpreted the prior statutory language. *See* H.R. Conf. Rep. No. 105-217, 105th Cong. 1st Sess. 870-71, *reprinted in* 1997 U.S.C.C.A.N. 176, 491-492 . Thus, subsection (a), entitled "Clarification Regarding State Liability for Medicare Cost Sharing," amended §1936a(n) by adding a new subparagraph (2) which provided that the payments made for Medicare cost-sharing by the states need not exceed the payment amount that would otherwise be made under the state Medicaid plan to an eligible beneficiary, and by adding a new subparagraph (3) prohibiting physicians and suppliers from "balance billing" an individual QMB to the extent that a state does not pay the full Medicare cost-sharing amount. 111 Stat. 510. The Ninth Circuit consolidated the appeals of five cases involving the same statutory construction issues, and requested and received supplemental briefing upon the effect of §4714 on the cases pending before it.

On December 2, 1997, the Ninth Circuit filed its decision reversing the district court's judgment. Seeing the resolution of the issue as relatively simple, the Ninth Circuit began its discussion by "eschew(ing) any analysis of [the] original arguments and turned instead to the validity and applicability of the 1997 enactment." 132 F.3d at 1264. Regarding the cases before it or still "pending," the court held that, "Because Congress has . . . the authority to *change* the law as to pending cases, its power to *clarify* the law -- to confirm what the law has always meant—follows a fortiori." *Id.* at 1265.

Relying on this Court's decisions in *Red Lion Broadcasting Co. v. FCC*, 395 U.S. 367, 381-382, n. 8 (1969) and *Loving v. U.S.*, 517 U.S. ____, 116 S.Ct. 1737, 1749, 135 L.Ed.2d 36, 57 (1996), the Ninth Circuit accepted the proposition that congressional legislation clarifying or interpreting the intent of an earlier statute must be accorded "great weight." It attempted to distinguish other cases that rejected the competence of a later Congress to opine on the meaning of an earlier statute on the ground that those cases involved less formal types of legislative history, such as House and Senate reports, rather than formal legislation from Congress as a body. 132 F.3d at 1265.

The court then justified its deference to Congress' 1997

"clarification" of the 1986 QMB legislation on the ground that it found the earlier statutory language "baffling" and lacking any clearly established meaning before §4714 was adopted. The court disregarded the unanimous judgments of the Second, Third, Fourth and Eleventh Circuits, as well as their uniform rejection of the Secretary's interpretation of the statute (which Congress embodied in §4714), on the grounds that (with the exception of *Haynes*, which followed *Snider*), they appeared to use different rationales to support their respective opinions. 132 F.3d at1266. The Ninth Circuit's opinion contains no discussion of the language, legislative history or the intent of the 1986 legislation that originally established the state's obligations under the QMB program, nor does it attempt to explain how the 1997 "clarification" comports with the purposes of this original legislation. Nevertheless, the Ninth Circuit concluded it should "honor Congress 'clarification' label and accept. . . §4714's provisions as a statement of what Section 1396a(n) has meant all along." 132 F3d at 1266. It reversed the district court's judgments in favor of Petitioners, thereby mooting Petitioner's constitutional claims. *Id.*.

A. The Seventh Circuit's *Paramount* Decision

On March 19, 1998, only a few months after the Ninth Circuit's decision, the Seventh Circuit decided the identical issue of law in *Paramount Health Systems, Inc. v. Wright*, 138 F.3d 706. ("*Paramount*") (1998). In *Paramount*, the Seventh Circuit recognized that, prior to Congress' 1997 clarifying amendments, four circuits had unanimously found that the 1986 QMB legislation unambiguously required the states' reimbursement obligation to be based on the Medicare rather than Medicaid rates, and had unanimously rejected the Secretary's position as entirely untenable. Further, the court seriously questioned whether §4714 of the 1997 Balanced Budget Act represented a *bona fide* clarification of the 1986 QMB legislation, observing that it was included in a statute principally concerned with cutting the federal budget, and that it was passed 11 years after the 1986 QMB legislation by a Congress whose membership had substantially turned over in the intervening years and whose veteran members would be unlikely to remember what the 1986 Congress' intention had been regarding the "esoteric issue" of the reimbursement rate

for medical services to QMBs. The court also noted that nothing in the 1997 provisions themselves suggested a process of interpretation, "they merely declare that the states are not required to reimburse QMB providers at the Medicare rate," citing *SEC v. Sloan*, 436 U.S. 103, 118, (1978) (thoroughness evident in agency's consideration and validity of its reasoning are factors for court to consider in evaluating persuasive force of ruling). 138 F.3d at 710. In view of these factors, the Seventh Circuit found particularly apropos this Court's holding that, "[T]he views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one," citing *United States v. Philadelphia Nat. Bank*, 374 U.S. 321, 348-349 (1963) and *South Dakota v. Yankton Sioux Tribe*, ____ U.S. ____, 118 S.Ct. 789, 803-804 (1998) 138 F.3d at ___. Accordingly, the court suggested that a "far more realistic" view was that §4714 was designed to change the original 1986 legislation in order to reduce the cost of Medicaid to the federal government. *Id.* at 710.

Nonetheless, Judge Posner noted that this Court, somewhat contradictorily, had also declared that subsequent legislation "declaring the intent of an earlier statute is entitled to great weight in statutory construction," citing *Loving*, *Red Lion* and *Consumer Product Safety Comm'n v. GTE Sylvania, Inc.*, 447 U.S. 102, 118, n. 13 (1980) ("*GTE Sylvania*"). Judge Posner stated that he was unable to reconcile the *Loving* line of cases with the *Philadelphia Nat. Bank* line of cases, holding that the views of a later Congress form a hazardous basis for inferring the intent of an earlier Congress. Implicitly rejecting the Ninth Circuit's rationale, Judge Posner noted that the principles articulated in the latter line of cases had been employed not only in cases involving mere legislative materials, committee reports, and the like, but also in cases involving subsequent legislation, including *Yankton*, which Judge Posner described as the "Supreme Court's latest word on the subject." 138 F.3d at 711.

As a consequence, the Seventh Circuit found itself in a "quandary" over the continued vitality of *Loving* and expressly invited clarification from this Court. Pending such clarification, however, and although acknowledging that the providers had the "better interpretation" of the original statute, the Seventh Circuit felt constrained to give enough weight to the 1997 Congress' declaration of intent to "tip the balance in favor of Chevron

deference" and, accordingly, also reversed the district court judgment for the providers. *Id.*

REASONS FOR GRANTING THE PETITION

Review is necessary in this case for a host of reasons. First, six of the circuit courts of appeals are directly split as to the proper interpretation of important provisions of the Medicare and Medicaid Act defining the reimbursement obligations of the states for Medicare services provided to QMBs. (*McElroy v. U.S.*, 455 U.S. 642 (1982) (conflict among the circuits a strong basis for review).) Second, resolution of the statutory construction issue also implicates an important jurisprudential question, i.e., what weight, if any, should the courts accord to a later Congress' declaration as to the meaning or intent of legislation enacted by an earlier Congress, an issue on which this Court's decisions are seemingly diametrically inconsistent, and the answer to which this Court has already recognized "is not free of ambiguity." *McDaniel v. Sanchez*, 452 U.S. 130, 138 (1981). This question is important because of the increasing frequency of Congress' use of the "clarification" device when amending federal legislation.[6] This question is especially important here because, if §4714 plainly constitutes a change in rather than a clarification of the 1986 QMB legislation, its retroactive application to deny reimbursement to providers for medical services already rendered to patients under the QMB program impairs their protected property rights to payment for these services in violation of Article 1, §10, and the "takings" clause of Amendment V to the U.S. Constitution.

I. Review Is Necessary To Resolve A Dispute As To The Meaning And Intent Of The Statutory Scheme Defining The States' Obligation To Reimburse Health Care Providers For Medicare Services Previously Rendered On Which Issue The Decisions Of The Ninth

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[6] The 1997 BBA itself contains no less than 17 "clarifications" of previously enacted legislation. App. 40-42.

And Seventh Circuits Directly Conflict With Those Of The Second, Third, Fourth and Eleventh Circuits.

Centrally at issue in this case is the meaning and intent of the QMB legislation, as enacted by Congress in 1986. The resolution of this question is unquestionably a judicial, not legislative, function. *Pierce v. Underwood*, 487 U.S. 552, 566 (1988) ("it is the function of the courts and not the Legislature . . . to say what an enacted statute means"); *Marbury v. Madison*, 5 U.S. 137 (1803). In determining the meaning and intent of the 1986 QMB legislation, the Second, Third, Fourth and Eleventh Circuits each engaged in an independent examination of the relevant statutes and their legislative history, available judicial precedent and the historical and contemporary administrative constructions of the statutes before concluding that Congress clearly and unambiguously intended to define the States' reimbursement obligation for Medicare services to QMBs based on the Medicare, not Medicaid, rates.

In sharp contrast, neither the Ninth Circuit in this case nor the Seventh Circuit in *Paramount* engaged in any such analysis. Rather, in concluding that the 1986 QMB legislation permitted the States to limit their reimbursement share for Medicare services to QMBs to lower Medicaid rates, the Ninth Circuit uncritically deferred to the 1997 Congress' purported "clarification" of the statutory scheme. Its opinion contains no analysis of either the meaning and intent of the 1986 legislation or the reasonableness of the 1997 "clarification," nor any consideration of the considered analyses and directly contrary judgments of the Second, Third, Fourth and Eleventh Circuits. The Seventh Circuit's *Paramount* decision is more considered, and clearly more troubled by the judgment it felt compelled to reach. Ultimately, however, that court also deferred to the 1997 Congress' purported "clarification" of the 1986 QMB legislation, issuing nothing more than a passing discussion of the meaning and intent of the 1986 legislation and entirely disregarding the analyses of the earlier four circuits, which demonstrated that the construction of the 1986 legislation advanced by the 1997 Congress, as then asserted by the Secretary, was not even a "reasonably possible" interpretation of the statutory scheme. *See Chevron USA v. Natural Res. Def. Council*, 467 U.S. 837, 843-844 (1984).

As discussed below, the Ninth and Seventh Circuit opinions squarely present the important jurisprudential question whether, and subject to what principles and standards, the courts should defer to a later Congress' interpretation of earlier enacted legislation in performing their Article III function to interpret that earlier legislation. The proper construction of the 1986 legislation governing the measure of the States' obligation to share in the reimbursement of providers of Medicare services to QMBs remains an independently important issue profoundly affecting the fiscal stability and viability of providers in the state of California.

The Ninth Circuit's deference appears to be in fact an abdication of its Article III duty to interpret the legislation at issue before it. Nothing in the opinion reveals the results of the court's own independent efforts to determine the intent of the 1986 Congress other than its assertion that ascertaining Congress' intent in enacting §1396a(n) would be difficult. But difficulty alone does not relieve the courts of their independent duty to ascertain the meaning of a statute. In *Perales*, the Second Circuit noted that, despite the complex nature of the statutory scheme, it had a duty to use the ordinary tools of statutory construction such as the text, structure and history of the legislation at issue to discover its purpose; and where the process identified a purpose clearly at odds with a proffered administrative interpretation, not to defer to it. *Perales*, 954 F.2d at 862-3. Here, the Ninth Circuit's opinion fails to analyze why the 1986 Congress enacted the QMB legislation, how §1396a(n) fits into the legislative plan, and how or why it concluded that the 1997 Congress's interpretation, without the benefit of an analysis of the 1986 legislation, reasonably effectuated the 1986 Congress's intent. *Cf. Universities Research Assn. v. Coutu*, 450 U.S. 754 (1980).

Unlike the Ninth Circuit, the Seventh Circuit recognized the "unreality" of giving great weight to the 1997 Congress' view of the 1986 Congress' intent, where the purpose of §4714, as part of the Balanced Budget Act, was to reduce the cost of Medicaid and the provision lacked any explanation as to how the 1997 Congress had determined the intent of the 1986 Congress. 138.F.3d 710. Nonetheless, believing §1396a(n) to be ambiguous and, believing itself bound to some extent by the *Loving* precedent, the Seventh Circuit, gave sufficient deference to

Congress' clarification to tip the scale toward *Chevron*-like deference in favor of the government's position.

The Seventh Circuit's analysis, however, is flawed. Even assuming that §1396a(n) is ambiguous, which none of the four earlier circuits found to be the case, that fact does not compel automatic deference to Congress' position. In order to fulfill their Article III duties, the courts must still determine whether Congress' position represents a *reasonable* interpretation of the statute. *Cf. Chevron*, 467 U.S. at 843-844. As this Court stated in *SEC v. Sloan*, 436 U.S. at 118, "the courts are the final authorities on issues of statutory construction and are not obliged to stand aside and rubber-stamp their affirmance of administrative decisions that they deem inconsistent with a statutory mandate or that frustrate the congressional policy underlying a statute." Here, the four other circuits after analyzing the purpose and intent of §1396a(n) each considered and specifically rejected the Agency's position as unreasonable.[7] Yet the Seventh Circuit paid little heed – and the Ninth Circuit unfortunately paid no heed -- to their analysis when confronted with precisely the same construction in §4714.

The four earlier circuit decisions, however, recognized that QMBs were Medicare, not Medicaid, patients, and that the 1986 legislation was designed to provide Part B Medicare coverage they were too poor to obtain for themselves, but which "dual eligibles" were already receiving from the States under §1396a(a)(15). See 48 Fed.Reg. 10378, 10379 (Mar. 11, 1983); *Perales*, 954 F.2d at 860. The Secretary's interpretation of §1396a(n) frustrated that intent.

When Congress enacted the QMB statutes in 1986, medical services providers who did not take an assignment from their Medicare patients could bill the patients for the balance due

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[7] See *Perales*, 954 F.2d at 858 (Secretary's interpretation "at odds with the *clear* intent of the statutes, both facially, and as elaborated by legislative history"); *Kozlowski*, 42 F.3d at 1459 (rejecting Secretary's position because "there can be no doubt" as to statutory meaning); *Snider*, 29 F.3d at 901-902 (finding that Secretary's interpretation defeated congressional intent underlying the QMB program); *Haynes*, 36 F.3d at 1076 (same).

after Medicare paid its 80% of the covered cost. Because it would generally be difficult, if not impossible, for QMBs to pay the balance due, the 1986 statutes were designed to transfer this financial burden to the State. As the Third Circuit recognized, this purpose clearly appears from the contemporary House Report explaining the program:

> For elderly and disabled individuals whom the State chose to cover, the Medicaid program would pay for the Part B deductible and the beneficiary's 20 percent coinsurance on Part B services. If the beneficiary uses a physician who takes assignment, Medicaid would pay the physician directly for the 20 percent coinsurance and the patient could not be billed for any amounts above the Medicare reasonable charge. However, if the physician elects not to take assignment, the beneficiary would submit the claim for the 20 percent coinsurance requirement to the State Medicaid program and would be liable for an additional amount charged by the physician.

H.R. Rep. No. 99-727, 99th Cong., 2d Sess. 106 (1986) reprinted in 1986 U.S.C.C.A.N. 3607, 3696; *see Snider*, 27 F.3d at 901.

The Secretary's position that Section 1396a(n), by implication, was intended to limit the State's obligation to the Medicaid rate obviously contravenes the purpose of the statute. If the State paid only the Medicaid rate, QMBs would be liable for the entire amount due under the Medicare reimbursement principles even if their physicians accepted assignments, which they had no obligation to do. The net result, of course, is that QMBs would again bear the obligation to pay the balance of the bill – the exact outcome Congress intended to avoid. *Cf.*, *Snider* at 901.

Snider, *Perales*, *Haynes* and *Kozlowski* construed §1396a(n) as an authorization to make payments for QMB services at the Medicare rate rather than at the Medicaid rate required to be set forth in the State plan. *Snider* observed that §1396a(n) could be reconciled with §1396a(10)(E)(i) by construing it to authorize the States to pay more than the Medicaid rates, while the Secretary's contention that §1396a(n) authorized the States to limit payments for QMBs would do "irreconcilable harm" to §1396a(10)(E)(i)'s mandate of full

payment of Part B cost sharing. *Snider*, 29 F.3d at 896; *Perales*, 954 F.2d at 859-60.

The Seventh Circuit questioned this analysis on the grounds that if §1396a(a)(10)(E)(i) clearly entitled providers to full Medicare reimbursement rates, the States could hardly be penalized for such reimbursements, and that since the beginning of Medicare and Medicaid, providers of services to dual-eligibles had been paid at the Medicare rate without any threat of penalties. Even if correct, this observation does not diminish the validity of *Snider's Perales'* and *Haynes'* interpretation of §1396a(n). First, there appears to be no reason why Congress could not make specific by §1396a(n) that which is implied by §1396a(a)(10)(E)(i), i.e., that payment of Medicare rates is authorized even if they exceed the stated Medicaid rates.. Indeed, the Conference Report indicates that was precisely the purpose of §1396a(n):

> (c)Payment amounts – Provides that the total of Medicaid payments for Medicare cost-sharing charges under this provision together with Medicare payments may exceed the amounts otherwise payable under the State Medicaid plan for such services.

H.R. Conf. Rep. No. 99-1012, 99th Cong., 2d Sess., 395-96 (1986) reprinted in 1986 U.S.C.C.A.N. 3868, 4040-4041. As *Snider* noted, "(t)his language emphasizes the comparison between Medicare and Medi-Cal rates of payment, rather than the discretion of the states" to eliminate or reduce cost-sharing payments. *Snider*, 29 F.3d at 895. Second, the QMB program was new, separate and distinct from the ongoing "dual-eligible" program, so precedent from the latter was not necessarily controlling as to the former. Finally, as already noted, the Secretary's interpretation directly contravened the intent of the statute, by ultimately placing the burden of Part B cost sharing on the very aged poor whom the law was intended to benefit. *Id.*, at 901.

In sum, totally missing from the Seventh and Ninth Circuits' opinions is any explanation as to how construing the 1986 QMB legislation to allow States to limit their obligatory share of the costs of Medicare services to QMBs to the Medicaid rate in any way furthers the 1986 Congress' intent to make otherwise unaffordable Medicare services available to QMBs.

Since the Secretary's interpretation of the statute necessarily yields a result directly contrary to that Congress intended, i.e., with the QMBs responsible for the entire unpaid balance, the Second, Third, Fourth and Eleventh Circuits properly rejected it as an entirely untenable construction of the 1986 legislation. The 1997 Congress' "clarification" of that legislation, which is identical to the Secretary's interpretation that the courts have universally rejected as unreasonable, should not command any greater deference.

II. Review Is Necessary To Resolve An Apparent Conflict Among This Court's Decisions And To Clarify The Principles And Standards Governing The Deference, If Any, The Courts Should Give A Subsequent Congress' "Clarifications" Of Legislation Enacted By An Earlier Congress. Under Any Standard of Deference, The Ninth Circuit's Deferral To The 1997 Balanced Budget Act "Clarification" Of The 1986 Medicare Legislation Was Unwarranted.

The Ninth and Seventh Circuits ultimately reached their judgments as to the meaning of the 1986 QMB legislation only by giving conclusive weight to the 1997 Congress' purported "clarification" of the meaning of that earlier legislation. This Court's cases, however, appear to state two diametrically opposed rules as to the proper weight to be given to such subsequent congressional expressions, an inconsistency that left a respected Seventh Circuit in a "quandary" and led it to expressly request clarification from this Court on the issue.

As already noted, "it is the function of the courts and not the Legislature ... to say what an enacted statute means." *Pierce*, 487 U.S. at 566.[8] As a corollary to this basic principle, this Court

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[8] As this Court observed over 100 years ago: "'In this country, where the legislative power is limited by written constitutions, declaratory laws, so far as they operate upon vested rights, can have no legal effect on depriving a individual of his rights or to change the rule of construction as to pre-existing law. . . . [T]hey can have no binding effect; and if the judge is satisfied the legislative construction is wrong, he is bound to disregard it.'

(continued...)

has observed that it is the intent of the enacting Congress, not the views of a later Congress, that controls the courts' construction of an enacted statute. *See, e.g., Public Employees v. Betts*, 492 U.S. 158, 168 (1989); *Oscar Mayer & Co. v. Evans*, 441 U.S. 750, 758 (1979).

Accordingly, this Court has frequently stated unequivocally that the views of a subsequent Congress on the meaning of legislation enacted by an earlier Congress has little, if any, significance. *See, e.g., Yankton*, 118 S.Ct., at 803-04; *Public Employees v. Betts*, 492 U.S. at 168 ("We have observed on more than one occasion that the interpretation given by one Congress . . . is of little assistance in discerning the meaning of [a prior] statute"); *Gwaltney v. Chesapeake Bay Foundation*, 484 U.S. 49, 63 fn. 4 (1987) (rejecting 1987 Congress' view of 1982 Clean Water Act: "The conclusions of the 99th Congress ... are hardly probative of the intent of the 92nd Congress"); *U.S. v. Price*, 361 U.S. 304, 313 (1960) (1946 Congressional interpretation of 1939 Internal Revenue Code "form a hazardous basis for inferring the intent of an earlier [Congress]"); *Rainwater v. U.S.*, 356 U.S. 509, 593 (1958) (Congress' 1918 interpretation of 1863 False Claims Act "has very little, if any significance").[9]

On the other hand, this Court has also asserted that such

(...continued)

(T)o declare what the law is, or has been, is a judicial power, to declare what the law shall be is legislative, and that one of the fundamental principles of all our governments is, that the legislative power shall be separate from the judicial, this court interrupted them with the observation that it was unnecessary to argue that point." *Koshkonong v. Burton*, 104 U.S. 668, 26 L.Ed. 886, 890 (1882) (*emphasis added*); see also *Stockdale v. Atlantic Ins. Co.*, 87 U.S. 323, 22 L.Ed. 348, 351 (1874).

[9] Additional cases finding a later Congress' views a "hazardous basis" for inferring earlier legislative intent include: *Philadelphia Nat. Bank*, 374 U.S. at 349-349; *O'Gilvie v. U.S.*, 519 U.S. _____, 117 S.Ct. ____, 136 L.Ed. 454, 464 (1996); *U.S. v. X-Citement Video, 513 U.S. _____, 115 S.Ct. 464,* 130 L.Ed.2d 372, 384 n.6 (1994); *Central Bank of Denver, N.A. v. First Interstate Bank of Denver,* 511 U.S. 164 (1984), *U.S. v. Texas,* 507 U.S. 511, 535 n. 4 (1993).

subsequent congressional views are entitled to "great weight" in interpreting the meaning of earlier enacted legislation. *See, e.g., Loving v. U.S.*, 116 S.Ct. at 1749..[10]

The Ninth Circuit attempted to harmonize these seemingly conflicting lines of cases on the basis that those that questioned the competence of a later Congress to opine on the intended meaning of an earlier statute did not involve Congress acting as a body, but rather involved less formal types of subsequent legislative history such as Senate and House Committee reports. But as Judge Posner observed in *Paramount*, that postulated distinction breaks down in view of this Court's cases rejecting subsequent Congressional views that do involve the entire Congress. *See, e.g., Public Employees v. Betts*, 492 U.S. at 168; *Gwaltney*, 484 U.S. at 63 n. 4; *Price*, 361 U.S. at 313; Rainwater, 356 U.S. at 593. Indeed, the Ninth Circuit apparently recognized, but then inexplicably ignored, that its own attempted distinction fell short when it expressly noted that, in *Mackie v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988), this Court had rejected not only a House Committee report, but also the later statutory enactment of that report as a basis for inferring the intent of an earlier Congress.

The Seventh Circuit was far more troubled than the Ninth Circuit by the doctrinal uncertainty caused by these apparently conflicting principles under these two lines of cases. The Seventh Circuit's disturbance was warranted. As Judge Posner observed, these lines of cases are seemingly irreconcilable on a doctrinal level. 138 F.3d at 711. Moreover, the issue is presenting itself with increasing frequency. The 1997 Balanced Budget Act itself contains no less than 17 purported "clarifications" of previously enacted legislation. App. 40-42. Indeed, only recently this Court

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[10] Additional cases giving "great weight" to an earlier Congress' declaration include: *GTE Sylvania, Inc.*, 447 U.S. at 118 n. 13; *Red Lion*, 395 U.S. at 380-381; *Federal Housing Adm. Darlington, Inc.*, 358 U.S. 84, 90 (1958); *Gladden Co. v. Zdanok*, 370 U.S. 530 (1962); *Seatrain Shipbuilding Corp. v. Shell Oil Co.*, 444 U.S. 572 (1980); *Bell v. New Jersey*, 461 U.S. 773 (1983); *Gozlon Peretz v. U.S.*, 498 U.S. 395 (1991); and *Bufferd v. Commissioner*, 506 U.S. 523 (1993).

granted certiorari and remanded to the Seventh Circuit Court of Appeals a case presenting precisely this issue arising out of the 1997 Balanced Budget Act. *See Doherty v. Pennington*, _____ U.S. _____, 139 L. Ed.2d 225 (1998), rev'g mem. 110 F.3d 502 (7th Cir. 1997). Especially when coupled with the direct split among six of the circuits on the underlying important statutory construction issue, therefore, this doctrinal uncertainty on a matter going to the heart of the principles on which the separation of legislative/judicial powers doctrine rests strongly supports this Court's review in this case.

That in deferring to Congress' 1997 "clarification" both the Ninth and Seventh Circuits failed to fulfill their Article III duty to independently determine the meaning of the 1986 legislation, underscores the need for this Court's review. The Ninth Circuit's apparent avoidance of this responsibility is particularly disturbing because it rests on a misconception of the nature of the 1997 congressional action. As the basic premise of its analysis, the Ninth Circuit states that "[b]ecause Congress ... has ... authority to *change* the law as to pending cases, its power to *clarify* the law – to conform to what the law has always meant – follows a fortiori." 132 F.3d at 1265 (emphasis in original). Whatever authority Congress may have to clarify a law, however, cannot be viewed as merely subsumed within Congress' power to legislate, because it involves a distinctly different, in fact judicial, function. Proceeding from this flawed premise, the Ninth Circuit's decision failed to independently determine for itself either the meaning and intent of the 1986 QMB amendments, or whether §4714, which embodied the Secretary's consistently rejected interpretation of the earlier legislation, was in any way a tenable reading of the legislation.

Furthermore, the nature of the 1997 amendments strongly negates any basis for deference in this case. As Judge Posner explained in *Paramount*, nothing in the context of the Congress' enactment of §4714 indicates that it was anything other than a material change in the 1986 legislation. Congress enacted §4714 as part of the 1997 Balanced Budget Act, for the express purpose of reducing expenditures and overturning the decisions of the Circuit Courts that had specifically rejected the substance of Congress' "clarification" as advanced by the Secretary. As this Court has long recognized, Congress' attempt to overturn

intervening judicial constructions of legislation by means of subsequently enacted interpretations of the earlier legislation are ineffective. *See Koshkonong*, 26 L.Ed. at 890 (later Congress' interpretation of a statute previously construed by the courts "can have no legal effect in depriving an individual of his rights, *or to change the rule of construction as to a pre-existing law*") (emphasis added); see also *U.S. v. Wise*, 370 U.S. 405, 414 (1962) (no weight given to how members of the 1914 Congress may have interpreted the Sherman Act as enacted in 1890).; *cf., Stockdale*, 22 L.Ed. at 351 (1870 legislation construing intent of 1864 tax statutes upheld because construction "was not in . . . essence at attempt to construe a statute differently from what the courts had construed it").

The 1997 Congress' purported clarification of the 1986 legislation to permit the states to limit their Medicare reimbursement obligation for services to QMBs to the Medicaid rate was in substance the same interpretation of that legislation that the Secretary had earlier advanced and which the four earlier cases had unequivocally rejected as untenably inconsistent with the intent of the 1986 legislation. Indeed, as already noted, the four earlier circuit decisions expressly refused to give any weight to the Secretary's interpretation, as would otherwise be required by *Chevron*, 467 U.S. 837, precisely because those courts each found the Secretary's interpretation to be contrary to the clear intent of the enacting Congress. *See fn.7, supra.*

Numerous other factors, many of which Judge Posner identified in *Paramount*, also militate against according any deference, let alone great weight, to the 1997 Congress' clarification of the 1986 legislation. Indeed, this Court has recognized these factors as a proper basis for declining to defer to a subsequent legislative view of an earlier Congress' legislative intent. These factors include:

1. The lapse of 11 years between the 1986 QMB legislation and the 1997 Balanced Budget Act: *Cf., U.S. v. Wise*, 370 U.S. at 413 (no deference to 1914 Congress interpretation of 1890 Act).

2. The turnover of the membership in Congress during this 11 year interval and the 1997 Congress' lack of knowledge of or insight into the intent of the 1986 members on the issue of QMB reimbursement. *Cf. U.S. v. United Mine*

Workers, 330 U.S. 258, 281-282 (1946) (Senators' opinion in 1943 not authoritative where they entered Senate after enactment of 1932 legislation).

3. The circumstances surrounding the enactment furnished no basis for inferring that Congress' clarification had been "courtlike," i.e., suggesting a process of interpretation, where §4714 had been passed as part of the 1997 Balanced Budget Act, which was primarily concerned with cutting the federal deficit. *Paramount*, 138 F.3d at 710.

4. The 1997 legislation was "litigation inspired," as evidenced by its express application to pending cases (an unnecessary expression if the §4714 applied only clarified earlier legislation), rather than constituting a direct response to the four circuit decisions which had been rendered 3-5 years earlier.

5. Deferring to the 1997 amendments as a clarification, rather than a retroactive change in the applicable law governing reimbursement to QMBs, is particularly unwarranted where the later Congress' interpretation of the earlier statute impairs or violates constitutionally protected rights. *Stockdale*, 22 L.Ed. at 351; *Koshkonong*, 26 L.Ed. at 890.

Given the coalescence of the factors summarized above, this case presents the precise circumstances under which a later Congress' views provide a hazardous basis indeed for inferring the intent of earlier legislation. The seriousness and importance of the jurisprudential and separation of powers issues implicated by the Ninth and Seventh Circuit decisions strongly support review in order to clarify the law governing the deference, if any, the courts owe to the views of a subsequent Congress regarding earlier enacted legislation.

III. Section 4714's "Clarification" Of §1396a(n) Violates The Separation Of Powers Doctrine

To the extent §4714 of the Act purports to clarify §1396a(n), it runs afoul of the doctrine of separation of powers that underlies Article III. Under that doctrine, a court will construe as unconstitutional legislation enacted by Congress which prescribes a rule of decision in a case pending before the court in a manner that requires the court to decide the controversy in the Government's favor. *U.S. v. Klein*, 13 Wall 128, 20 L.Ed. 519 (1872); *U.S. v. Sioux Nation of Indians*, 448 U.S. 371, 404

(1980). Here, prior to the enactment of the Act, four circuit courts had unanimously agreed that §1396a(n) did not allow the states to limit Medicare cost sharing to the Medicaid rate and had specifically rejected the Government's contrary interpretation of the statute as contrary to the 1986 Congress' intent. In effect, newly added §1396a(n)(2) now mandates that the Government's previously rejected position be accepted.

Thus, Congress in effect has prescribed the new rule of decision as to §1396a(n) cases, but that rule operates not only prospectively, but under the express provision of subsection (c) of §4714, is made retroactive to apply to payments by a state for items and services furnished before such date "if such payment is the subject of a lawsuit that is based on the provisions of sections 1902(u) (§1396a(n)) and 1905(p) (§1396d(p))."

By thus "clarifying" §1396a(n) to give it an interpretation which the Government had previously advocated, but which the courts had previously rejected and then making its provisions retroactive as to all pending litigation, the Government has assured that any court now confronted with the controversy will be required to decide it in the Government's favor. And the Government has done this through a law that in its retroactive aspects is not a law of general application, but rather operates only as to pre-Act payments that are the subject of §1396a(n) lawsuits pending as of or initiated after the date of the Act's enactment, i.e., August 5, 1997. *Klein* and *Sioux Nation* preclude such a result.

The Ninth Circuit recognized exactly what Congress intended to do. "What is . . . significant is that Congress' characterization plainly reflects its intention to resolve every still-live dispute in the manner specified by the new legislation." (132 F. 3d at p. 1264.) The court might have added "i.e., in the Government's favor." Yet, the Court concluded that since "Congress has authority . . . to *change* the law as to pending cases, its power to clarify the law – to *confirm* what the law has always meant – follows a fortiorari." 132 F.3d at 1265.

This statement is fundamentally flawed. While Congress has the power to *amend* the law and make such a change retroactive, such power is subject to express constitutional limits, such as the prohibition against "impairing the Obligations of Contracts" (Art., §10, cl.1), or against depriving private persons

of vested property rights except upon payment of "just compensation" (Fifth Amendment's Taking Clause). *Landgraf v. USI Film Products*, 501 U.S. ____, 128 L.Ed.2d 229, 253 (1994); *cf. U.S. v. Schooner Peggy*, 1 Cranch 103, 110, 2 L.Ed.49, 51 (1801). However, it is equally clear that Congress does not have power to attempt to sidestep these fundamental constitutional limitations by "confirm(ing) what the law has always meant" because "to declare what the law is, or has been, is a judicial power, to declare what the law shall be is legislative, and one of the fundamental principles of all our governments is, that the legislative power shall be separate from the judicial . . ." *Koshkonong*, 104 U.S. 668, 26 L. Ed. 886, 890; *see also Stockdale*, 87 U.S. 323, 22 L.Ed. 348, 351.

To the extent therefore that Congress' "clarification" purports to "confirm" what §1396a(n) "has always meant," it usurps a power that resides solely in the judiciary.

IV. Review Is Necessary Here Because The Retroactive Application Of The Substantial Amendments To The 1986 QMB Legislation Effected By §4714 Of The 1997 Balanced Budget Act Unconstitutionally Impairs Substantial Protected Property Rights.

As the preceding discussion makes clear, §4714 of the 1997 Balanced Budget Act fundamentally alters, rather than narrowly clarifies, the 1986 QMB legislation pertaining to State reimbursement for Medicare services provided to QMBs. As four courts of appeals have unanimously concluded, the 1986 legislation required States to reimburse providers at Medicare rates rather than permitting the States to cap their reimbursement obligation at the substantially lower Medicaid rates. Section 4714 reverses that limitation and explicitly permits States to cap their reimbursement obligation at Medicaid, not Medicare rates.[11]

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[11] Other additions by §4714 underscore the fact that §1396a(n) was being changed, not clarified. Subparagraph (a)(2) (111 Stat.510) prohibits a provider from "balance billing" a beneficiary for the amount of the 20% coinsurance or deductible eliminated under the new Medicaid payment cap, whereas the prior statute, although providing for assignment, did not cap the

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Section 4714(c) selectively applies the amendments' provisions retroactively only to litigation pending on or initiated after the Amendment's effective date so as to deny providers full reimbursement for services already provided to patients. This Court has established a strong presumption against retroactivity and has made abundantly clear that the retroactive application even of ordinary legislation requires careful scrutiny so that the public's constitutionally protected rights and legitimate expectations are not adversely impaired. *See, e.g., Landgraf v. USI Film Products*, 511 U.S. ___, 114 S.Ct. 1483, 128 L.Ed.2d 229, 252-53 (1994); *Bowen v. Georgetown University Hospital*, 488 U.S. 204, 208 (1988). The retroactive application of §4714 falls squarely within this doctrinal caution, for its application here plainly deprives providers of vested contractual rights to reimbursement for services previously rendered in direct violation of the Takings Clause of the Fifth Amendment to, and impairs fixed contractual rights in violation of Article 1, Section 10 of, the U.S. Constitution.

First, this Court has recognized that "[r]rights against the United States arising out of a contract with it are protected by the Fifth Amendment." *Lynch v. U.S.*, 292 U.S. 571, 579 (1934). As a corollary to this principle, "[w]hen the United States enters into contract relations, its rights are governed generally by the law applicable to contracts between private individuals." *Id.*, quoted with approval in *United States v. Winstar Corp*, 518 U.S. ___, 135, 116 S.Ct. ____, L.Ed.2d 964, 1004 (1996) (plurality opinion) ("*Winstar*").

Here, the relationship between health care providers and the federal and state governments within the Medicare and Medicaid structure is undisputedly contractual, an essential term of which is the providers' right to full reimbursement for their Medicare-allowed costs (including Medicare cost-sharing for services rendered to "dual eligibles"). *See Perales*, 954 F.2d at 858; *Stephenson v. Shalala*, 87 F.3d 350, 352 (9th Cir. 1996) (the

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payment due the provider. *See Snider*, 29 F.3d at 900.

"80-20" cost-sharing arrangement "*guarantees* health services providers payment for 100% of their Medicare-allowed costs") (emphasis added).

In describing this contractual relationship and the function of the Medicare Provider agreements under it, the courts have explained that "(t)he Provider agreement is a unique type of contract. It does not provide for a defined transaction or even a series of transactions. It simply establishes a relationship between the parties: *if [the provider] treats eligible patients, HHS will reimburse them for their costs.*" *University Medical Center v. Sullivan*, 973 F.2d 1065, 1081 (3rd Cir. 1992) (emphasis added). In effect, the Medicare Provider agreement is deemed an "executory contract" between the provider and the government. *Id.*, at 1076-1077.

Under the Medicare Provider agreement, a provider of Part B services such as a hospital agrees to look *exclusively* to the government (and not the patient) for payment, except for deductibles, coinsurance and copayment charges allowed under federal regulations. §1395cc(a); 42 C.F.R. §§489.30-489.32.[12]

In the case of "dual-eligibles," the contractual relationship between the government and the provider is expanded to include the state Medicaid program. In these circumstances, once the reasonable costs or charges are determined by the Secretary, a Medicare service provider is entitled to recover 100% of that amount: 80% from the Medicare program, §1395l, and 20% coinsurance from the state Medicaid program, §§1396a(a)(10)(E), 1396d(p)(3). See *Perales*, 954 F.2d at 859; *Snider*, 29 F.3d at 893. Generally, the provider may not bill the patient for any "balance" over and above the government-prescribed payment

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[12] Similarly, in the case of participating physicians, ambulance companies and suppliers, the Secretary of HHS enters into an "assignment agreement" with the provider under which the provider agrees to accept the Secretary's payment determination as *payment in full*, and is precluded from charging the Medicare enrollee more than the deductible and coinsurance based upon the approved charge determination by the Secretary. §§1395u(b)(3)(B), 1395u(h)(1).

rate. §1320a-7b(d).[13] *See* App. 43.

Thus, the essence of the contractual relationship between the petitioners' members and the government is the government's contractual responsibility for the 20% coinsurance and deductibles for medical services plaintiffs' members provided to these "dual eligible" beneficiaries. The economic burden of this debt falls in equal proportions on both the federal and state governments, since the federal government contributes 50 percent of the cost of administering the California Medicaid ("Medi-Cal") program. §1396b(a)(1), 1396d(b). With the enactment of §4714, Congress has elected to repudiate a part of that debt as part of a cost-saving measure designed to produce an estimated net federal savings of $2.1 billion over five years for the federal portion of the Medicaid program. *See*, Congressional Budget Office estimates re: Public Law 105-33. App. 48. This Court, however, has rejected the argument that Congress has the power to repudiate its own debts which constitute "property" to the debtor, simply in order to save money. *Winstar*, 135 L.Ed.2d at 1018 (Breyer, J., conc.).

Petitioner Associations do not challenge Congress' power to amend the terms of the underlying legislation on a prospective basis, for medical services not yet provided. Nonetheless, providers have a contractual right to payment of the 20 percent coinsurance at the Medicare rates for those services rendered prior to §4714's enactment, a right that vested at the time they performed such services in reliance on the payment rates established in the statute and regulations. As such, Congress cannot retroactively impair those vested rights.[14]

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[13] Emphasizing Congress' awareness of the contractual nature of the relationship between the federal government and providers, it is relevant to note that §4714(b) modifies the state Medicaid agency's cost-sharing obligations, so as to prohibit a provider from imposing any patient charge for any payment amount that is limited or reduced as a result of the new Medicaid payment – rate limitations authorized under §4714(a). §1395cc(a)(1)(A) (new).

[14] The Eighth Circuit Court of Appeals and the California courts have held that a *state* cannot constitutionally retroactively reduce Medicaid

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In *Lynch*, which governs this case, this Court rejected on Fifth Amendment grounds Congress' attempt to legislatively retract the government's obligations on insurance contracts to save money during the Great Depression: "Congress was without power to reduce expenditures by abrogating contractual obligations. To abrogate contracts, in an attempt to lessen government expenditures, would be not the practice of economy but an act of repudiation." *Lynch, supra*, 292 U.S. at 580. See also, *Perry v. United States*, 294 U.S. 330, 350-351 (1935) (rejecting government's attempt to avoid a bond debt: "Congress is authorized to pledge the credit [of the United States] as an assurance of payment as stipulated ... To say that Congress may withdraw or ignore that pledge is to assume that the Constitution contemplates a vain promise ...); *Bowen*, 477 U.S. 55 ("Congress does not have the power to repudiate its own debts .. simply in order to save money").

More recently, in *Winstar*, a plurality of this Court held that the government could be liable for breach of contract when Congress enacted legislation abrogating previously created contractual rights of certain thrifts during the savings and loan crisis. As Justice Souter noted in quoting Justice Brandeis' observation in *Lynch*, "[p]unctilious fulfillment of contractual obligations is essential to the maintenance of the credit of public as well as private debtor." *Winstar*, 135 L.Ed.2d at 964. Justice Scalia further observed in his concurring opinion that *Lynch* and *Perry* were the two principal cases "of this century holding that the Government may not simply repudiate its obligations." *Id.* at

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reimbursements to health care providers. *See Minn. Ass'n of Health Care v. Minn. Dept. of P.W.*, 742 F.2d 442, 450-451 (8th Cir. 1984) (provision of new legislation which retroactively limited the rates that Medicaid nursing home providers could charge to non-qualifying residents was held to be unconstitutional impairment of contracts); *California Medical Assn. v. Lackner*, 117 Cal.App.3d 522, 566 (1981) ("any retroactive decrease in reimbursement to physicians due to the new, uniform schedules ... would be an unconstitutional 'law impairing the obligation of contract'") *See* U.S. Const. Art. I, §10.

1022 (Scalia, J., concurring). In both cases, as here, "Congress specifically set out to abrogate the essential bargain of the contracts at issue -- and in both we declared such abrogation to amount to impermissible repudiation." *Ibid.*

Retroactive application of §4714 abrogates the essential bargain of the providers' reimbursement agreements by changing their most fundamental term, the basic rate of payment. It is fundamentally unfair and constitutionally infirm for Congress to tell a provider who has been promised $100 to provide a service, that after providing the service, the rate has been changed after the fact to $80. That in effect is what Congress has attempted to do here by its purported clarification of the 1986 QMB legislation.

CONCLUSION

The Ninth Circuit's decision is totally flawed on matters of important statutory and constitutional, as well as social and economic, dimension. For the reasons discussed above, the petition for writ of certiorari should be granted and the Ninth Circuit's decision reversed.

Respectfully submitted,

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